Adult Mental Health Block Grant FY 2007

CRITERION 1: Comprehensive Community-Based Mental Health Service Systems

Freedom Commission Goals:

Goal 1: Mental Health is Essential to Health: *Every individual, family and community will understand that mental health is an essential part of overall health.*

Goal 2: Early Mental Health Screening and Treatment in Multiple Settings*: Every individual will have the opportunity for early and appropriate mental health screening, assessment, and referral to treatment.*

Goal 3: Consumer/Family Centered Care: *Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.*

Goal 4: Best Care Science Can Offer: *Adults with serious mental illness and children with serious emotional disturbance will have ready access to the best treatments, services, and supports leading to recovery and cure. Accelerate research to enhance prevention of, recovery from and ultimate discovery of cures for mental illnesses.*

Transformation Activities:

reduction of the stigma associated with mental illness
suicide prevention
improving coordination of care among multiple systems
assuring individualized plans of care for all consumers
development of culturally competent services
aligning financing for mental health services for maximum benefit

Montana is a geographically large state but has a population of less than one million. Many people have been working in the mental health field for twenty or more years. Relationships have been forged and partnerships have been developed. The dedication and resourcefulness of Montana's providers is a resource that will ensure Montana continues moving in transformation of its mental health service system. This transformation will bring service provision more directly in alignment with the New Freedom Commission recommendations.

The Addictive and Mental Disorders Division has taken the New Freedom Commission Report to heart. Given this direction, the mental health system in Montana has begun evolving and developing the necessary tools for a recovery and consumer centered system. Montana has a long journey ahead but with the commitment of the stakeholders, providers, consumers and family members; transformation effort of the public mental health system will succeed.

The journey for the next year will include continued focus on: strength-based case management, co-occurring initiative, evidence based and promising practices, employment, peer support services, Service Area Authorities, crisis services, HIFA and Home and Community Based (HCBS) waivers, housing, and regional staffing to name only a few.

Mental Health Services

Montana State Hospital (MSH) is the only public inpatient psychiatric hospital in the state. The hospital provides short-term emergency care as well as extended treatment for adults admitted in accordance with civil involuntary and criminal court (forensic) procedures. Patients are admitted from across the entire state of Montana, often following a short stay in a psychiatric unit in a community hospital. State law governs admission and discharge procedures.

The hospital works closely with the adult care coordinators and licensed mental health providers across the state to coordinate care and to return individuals to their home communities for appropriate aftercare services. The hospital has a median length of stay of 44 days for people discharged following civil commitments. Criminal commitments generally have much longer stays.

A brief description of each program follows:

A Unit, Main Hospital

Program	**Social and Independent Living Skills (SILS) Pathway**
Status	**Licensed by State of Montana under Hospital Standards; Certified by CMS under federal Medicare & Medicaid Regulations**

The SILS Pathway on A ward is designed to stabilize and treat acute psychosis and affective disorders that impair judgment, social functioning, and independent living skills. After stabilization of symptoms, treatment focuses on helping people better understand and manage their psychiatric illness and to begin taking steps toward recovery. Groups and therapeutic activities are designed to provide learning and practice experiences that promote recovery and allow the individual to experience healthy patterns of living and an improved quality of life. Individuals have an opportunity to work on personal goals for recovery and movement to community placements.

B Unit, Main Hospital

Program	**Adaptive Living Skills (ALS) Pathway**
Status	**Licensed by State of Montana under Hospital Standards; Certified by CMS under federal Medicare & Medicaid Regulations**

The Adaptive Living Skills Pathway is designed to enhance the physical, mental and psychosocial well-being of individuals who have long-term psychiatric disabilities and/or significant physical limitations. Individuals placed in this pathway include those whose psychosis or cognitive limitations are such that they severely interfere with daily functioning. Significant physical impairments may be present as well. Groups and therapeutic activities are highly individualized and designed to 1) provide a daily schedule that promotes physical, cognitive, emotional and social health; 2) promote each individual's self-respect and quality of life by providing activities that allow for self-expression, personal responsibility and choice.

D Unit, Main Hospital

Program	**Management of Legal Issues (MLI) Pathway**
Status	**Licensed by State of Montana under Hospital Standards;**

The Management of Legal Issues Pathways is designed for people admitted to Montana State Hospital who have misdemeanor or felony charges pending and are in various stages of adjudication. The unit is also known as the Hospital's forensic unit. There are three main components to the program 1) evaluation of competency and related issues; 2) treatment to restore competency and fitness to stand trial; 2) treatment for individuals found guilty but mentally ill or not guilty by reason of mental illness in criminal proceedings. The MLI program also provides psychiatric evaluation and treatment for individuals transferred from facilities operated by the Montana Department of Corrections. In all aspects of programming on this unit, careful consideration is given to public safety and the perspective of victims.

E Unit, Main Hospital

Program	**Social and Independent Living Skills (SILS) Pathway**
Capacity	**25 beds**
Status	**Licensed by State of Montana under Hospital Standards; Certified by CMS under federal Medicare & Medicaid Regulations**

The SILS Pathway on E ward provides treatment for people experiencing a high level of disability due to impaired judgment, social functioning, and independent living skills resulting from a serious mental illness. People on E ward have psychiatric symptoms and presenting problems that are not easily resolved and present significant barriers to community placement. Programming focuses on development and attainment of personal goals and taking initial steps to work toward recovery.
Groups and therapeutic activities are designed to provide learning and practice experiences that promote recovery and allow the individual to experience healthy patterns of living and an improved quality of life.

Spratt Building

Program	**Coping and Co-Occurring Pathway (CCP)**
Status	**Licensed by State of Montana under Hospital Standards; Certified by CMS under federal Medicare & Medicaid Regulations**

The Coping and Co-Occurring Pathway Program is designed for individuals whose primary problem is maladaptive coping behavior including substance abuse. This includes suicidal and self-injurious behaviors, eating disorders, problems with anger, problems in interpersonal relationships including aggression and lack of assertiveness, treatment non-compliance behaviors, somatization, and severe substance abuse. This program provides stage-based, integrated treatment to address complex treatment needs with a recovery perspective that includes acceptance of the individual into a therapeutic community.

Johnson House

Program	**Transitional Living**
Status	**Licensed as a Mental Health Center Group Home by the State of Montana**

Johnson House provides transitional living for people preparing for discharge into a community mental health center group home or similarly structured aftercare service like adult foster care or assertive community treatment. Program focus is on development independent living and self-care skills and social adjustment from institutional care.

Mickelberry House

Program	**Transitional Living for People on Forensic Commitments**
Status	**Licensed as a Mental Health Center Group Home by the State of Montana**

Mickelberry House provides transitional living for people on forensic commitments who are preparing for a community placement. Program focus is on development independent living and self-care skills and social adjustment from institutional care.

Residential Care Unit

Program	**Maintenance and Transitional Care for Patients who are stable and awaiting placement in a community aftercare program**
Status	**No applicable licensure category exists**
	The Residential Care Program provides care and ongoing treatment for people who are stabilized and discharged from hospital care, but awaiting placement in a community program either because of legal status or bed availability. The majority of the people on the program are on forensic commitments. The program provides care and treatment intended to maintain improvements made on other hospital units and further promotes each individual's recovery.

Montana State Hospital has 405.4 full time employees and an annual budget of about $25 Million. The average daily census for FY 2006 was 199. There were 691 admissions during the year and about the same number of discharges. The hospital is certified for participation in the federal Medicare and Medicaid programs.

Montana Nursing Care Center (NCC) is the only state operated nursing care facility for individuals with mental disorders. The Center provides long-term care and treatment to people who require a level of care not available in communities or will not benefit from intensive psychiatric treatment.

Montana's mental health services are provided by a variety of local agencies including licensed mental health centers, independent private practitioners, and short-term psychiatric inpatient units in community hospitals. The community psychiatric inpatient units are located in Kalispell, Missoula, Billings and Great Falls. Five community mental health centers provide the majority of services. Four of the five agencies serve a multi-county region and each participating county appoints one commissioner to the center's governing board. Each governing board includes a primary consumer, a family member of a consumer, either a parent or a child with an emotional disturbance, and either a person representing the interests of the elderly or a health care professional. A.W.A.R.E., Inc., the fifth provider has offices state wide but adult services are primarily located in Glendive (group home only), Butte, Bozeman, Great Falls, and Missoula.

Licensed mental health centers provide the majority of the outpatient care for the adult population who qualify for Medicaid or Mental Health Services Plan (MHSP). They also provide a considerable amount of charitable care. However, long waiting lists to see the limited

number of psychiatrists available contribute significantly to the increase in hospitalizations in private psychiatric units as well as Montana State Hospital.

The five licensed mental health center providers are as follows:

Eastern Montana Community Mental Health Center serves seventeen counties in the eastern-most part of the state. This is a huge land area (47,747 square miles) with a population density of 2 people per square mile.

EMCMHC offers some level of services in all seventeen counties, although some communities are served on a part-time basis by staff traveling from offices in other counties. Targeted case management for adults is available throughout the entire service delivery area. Day treatment services for adults with severe mental illness are provided in Miles City, Glendive, and Sidney. A residential program (an adult group home and adult foster care) is located in Miles City.

Center for Mental Health Services (formerly Golden Triangle Mental Health Center) serves a twelve-county area in north central and southwest Montana. The two largest communities in the region are Great Falls (population 56,338) and Helena (population 25,383). Both have well-developed community support systems under the leadership of the mental health center including a well-coordinated program of day treatment, targeted case management, outpatient psychotherapy, medication management, supported employment, transitional and residential living (group home, semi-independent living, adult foster care), and Assertive Community Treatment (ACT) services. Services provided are psychotherapy in ten of the twelve counties of the service delivery system and targeted case management in all twelve counties. Medication review in the smaller satellite offices is on a consulting basis by psychiatrists based in Great Falls and Helena.

South Central Montana Regional Mental Health Center is located in south-central Montana. Their service delivery encompasses twelve counties.

The Mental Health Center provides comprehensive services in Billings including psychiatry, psychotherapy, day treatment, adult residential services, assertive community treatment (ACT), intensive case management, and drop-in services. The center has a cooperative relationship with vocational rehabilitation providers, allowing for a range of vocational service options. The center also works collaboratively with the Montana Department of Corrections and Department of Veterans Affairs. Two major community resources are the Billings Clinic, which has the state's largest psychiatric unit for short-term inpatient acute care and Rimrock Foundation, which provides crisis stabilization services and is also a state approved alcohol and drug provider.

In a collaborative effort between the mental health center, St. Vincent Hospital, Billings Clinic, and the City/County Health Department a Community Crisis Center has been established to provide crisis services 24/7 with the capability of having a person in crisis receive care up to 23 hours. After three years of collaboration the center opened in May 2006. St. Vincent Healthcare and Billings Clinic fund all the operational costs for the Community Crisis Center. The Community Crisis Center is a Limited Liability Corporation with each agency providing core staff.

In addition, Billings Clinic Behavioral Health (consisting of 9 full-time psychiatrists) partners with the South Central Montana Regional Mental Health Center and two private practice psychiatrists to provide on-call and psychiatric services to Billings and the Eastern region.

Western Montana Community Mental Health Center (WMMHC) serves fifteen counties in western and southwestern Montana. The area is the most populated region of the state with a density of more than ten people per square mile. WMCMHC has worked to provide a comprehensive service system in Missoula, Butte, and Kalispell. Each of these communities has psychotherapy, day treatment, targeted case management, psychiatric services, mobile crisis and crisis residential services. Kalispell Regional Hospital and St. Patrick Hospital in Missoula each have inpatient psychiatric services. WMCMHC provides psychotherapy, adult foster and group care, and case management services in the other twelve counties in the region. Missoula and Kalispell have Assertive Community Treatment (ACT) services. WMCMHC also provides medication monitoring to outlying communities by psychiatrists who travel from Missoula, Bozeman, and Kalispell.

A.W.A.R.E., Inc. provides limited services to adults with serious mental illness, including targeted case management, intensive community-based rehabilitation, and adult residential services. Services are provided in Bozeman, Missoula, Butte, Great Falls, and Glendive (group home services only).

Co-Occurring Initiative

Addictive and Mental Disorders Division has continued to contract with Dr. Ken Minkoff and Dr. Chris Cline to provide technical assistance in moving the substance abuse and mental health services towards a more comprehensive and coordinated service array and integration of services to the estimated 40% of SDMI adults with co-occurring issues.

Employment, Rehabilitation and Educational Services

Each of the mental health centers either have a vocational person on staff or have an agreement with the local vocational rehabilitation office. These persons help clients identify what most interested in pursuing and matches those interests with the person's capabilities. This includes both education and vocational services. Many persons complete their GEDs and some consumers have gone on to take college classes and obtain degrees. The centers have supportive employment as well as competitive placements.

AMDD has had standing cooperative agreements at the state level with the Montana Vocational Rehabilitation (MVR) Services Programs that outline their commitment to both supported and transitional employment programs since the inception of supported employment in Montana. While these agreements have served to define terms of service, and provide general guidance regarding the execution of employment services, both AMDD and MVR are committed to strengthening these relationships and increasing the incidence of successful, meaningful employment outcomes for persons with mental illness. To that end the agencies will strengthen service provision in Montana by providing technical assistance to local service communities for

the purpose of developing local Cooperative Agreements that reflect a commitment to building stable, sustainable return to work programs utilizing the coordinated assets of AMDD and MVR.

The AMDD and the MVR have jointly teamed up with the Center for Technical Assistance and Training (CTAT) from Denver Colorado to organize a cross agency systems change/program development work session in Billings Montana in August of 2006. The purpose of this workshop is to bring together the policy, financial and program managers from these agencies to initiate local agreements that will result in the creation of more Mental Health/VR employment programs in Montana communities. These agreements will result in the agencies working cooperatively as vocational rehabilitation counselors and the mental health centers for the purpose creating more and better employment outcomes using strengths based as the foundation. The target audience will be challenged to design sustainable employment programs from the ground up in the represented communities.

The employment specialist from Western Montana Mental Health Center and the Strengths Based Case Manager trainer from Colorado will be the trainers. The trainer from Colorado previously provided training to the mental health center case managers and supervisors. This will be a bonus to the training, as the mental health system will continue building on the skills already learned. The goal or expected outcome of this cooperative endeavor will be developing better working relationships and plans to better collaborate with traditional community services for the benefit of the consumer. The communities that have agreed to participate are Great Falls, Billings, Bozeman, Livingston and Hamilton.

The Department received funding from the Department of Labor to develop the infrastructure within the Department to allow persons to work and keep Medicaid. Fear of losing Medicaid is the number one fear of persons returning to work.

Transformation of Mental Health Services

The Dialectical Behavior Therapy (DBT) Steering Committee has ongoing training and consultation plans for the next two years. The Montana State Hospital, Montana State Prison and Montana Chemical Dependency Center have trained teams. This is a service proven effective in serving individuals who are traditionally consumers of high costly mental health services as well as emergency services. Billings has five trained teams with one being a youth residential treatment center; Bozeman has four teams and Gallatin Valley DBT Consultation Team which includes eight private practitioners; Butte has three teams which includes an adolescent residential treatment center; Great Falls has two teams; Missoula has three teams; and Helena, Kalispell, Libby, Livingston and Poplar each have one team.

Assertive Community Treatment (ACT) teams have expanded from Helena and Billings to include teams in Great Falls, Kalispell, and Missoula. The teams include an addiction specialist on the team. These programs have been given expanded funding to include non-Medicaid consumers. This has been a major issue in getting persons served by an ACT Team. Many of the participants were not Medicaid eligible and the mental health centers found themselves providing the service without reimbursement or not being able to provide the appropriate services. Each community has 70 slots for a total of 350 persons served in ACT. This service

has proven to be successful in keeping persons in the community rather than at the state hospital or in non-independent residential placements and reducing the days of inpatient hospital care.

Montana is moving towards a recovery-based system by incorporating strength based and recovery oriented services in the mental health system. One of the evidence-based practices is the implementation of peer services. However, Montana does not have an organized consumer base. We have required consumers to be at the table for planning mental health services but we do not have a mechanism in place to support consumers. We need to strategically plan the implementation of peer services and support the development of a recovery-based system.

The Mental Health Oversight Advisory Council (MHOAC) has included peer services as one of their three goals. MHOAC consists of over 50% consumer and family members, who make the council uniquely qualified to research, direct, and assist in the development of consumer driven services. The Council received technical assistance from National Association of Mental Health Planning Advisory Council (NAMHPAC) on various models on peer services for the November 2005 meeting.

Mental Health Services Bureau (MHSB) and Montana Mental Health Association funded five persons to attend facilitator training for Wellness Recovery Action Plan (WRAP) in July 2006. Two facilitators from each SAA will were trained. MHSB and Council will plan to have a Leadership Academy Training in spring 2007.

Service Area Authorities and Local Advisory Councils

Montana is continuing to stabilize the three Service Area Authorities (SAA): Eastern, Western and Central. All three SAAs have incorporated and registered with the Secretary of State. The boards are required to have 51% consumer and family member representation. The SAAs will provide guidance to the MHSB for services. The SAA will steer the system with the assistance from the Local Advisory Councils (LAC). The LAC total for Montana is 26 with Eastern SAA have 12, Central SAA has 7 and Western SAA has 7. MHSB will provide the financial and technical support.

The 2005 Legislative session allocated $875, 000 for developing community crisis planning. Following are the project summaries funded July 2006. These are one time funds.

- Eastern Montana Community Mental Health Center **$65,000**
  EMCMHC requested funding for three components in its proposal: (1) purchase of an additional portable teleconferencing monitor to expand its capacity to participate in teleconferences with mental health offices and facilities throughout the eastern region; (2) funding for a pilot project that would establish a 30-day eligibility for individuals who are at imminent risk to self or others by suicidal or homicidal ideations; and (3) supplemental funding for crisis response for MHSP beneficiaries.

- Center for Mental Health Center **$163,908**
  Center for Mental Health proposed to administer a recovery-oriented Crisis Peer Support Pilot Project that will utilize nationally-recognized experts to assist in the development of

Medicaid-reimbursable crisis peer support services. The grant will provide funding for a Program Director, support staff, peer training subcontractors, and travel and training expenses. Pilot will be implemented in both urban and rural settings.

- Rocky Mountain Development Council (Helena) **$207,984**
  Proposal for creation of a tri-county mental health crisis response partnership with funding oversight responsibilities shared by Lewis & Clark, Jefferson, and Broadwater counties. The grant will support a project director, operation of a non-secure crisis stabilization facility by Golden Triangle CMHC, and creation of a mobile crisis response team to provide 24/7 professional mental health assistance throughout the tri-county area.

- South Central Community Mental Health Center (Billings) **$139,700**
  Proposal for purchase and installation of Pathways Compass® case management system in ten rural hospitals in the Eastern Service Area Authority; provide regional WRAP training; and provide regional crisis intervention team (CIT) training for law enforcement personnel.

- Western Montana Community Mental Health Center – Butte **$231,126**
  Proposal for development of a peer-to-peer consumer recovery and support system and for assistance with funding for the building of a non-medical crisis stabilization facility in Butte. The facility will include a total of 12 beds, with the capacity for 4 of those beds to be locked and to detain people involuntarily if so ordered by the court. It will also include the capacity to use 2 beds for detoxification and 6 beds for voluntary crisis stabilization.

- Western Montana Community Mental Health Center – Hamilton **$67,300**
  The proposal seeks to plan, develop and construct a crisis center providing 4 beds for community residential crisis stabilization and/or detox services and an additional four transitional beds for persons needing longer term stabilization. Grant will support a project coordinator, travel and office expenses, and architectural fees. The grant will also support WRAP training for consumers in Ravalli and western Beaverhead counties.

Strengths Based Case Management

MHSB continues to implement strengths based case management in Montana. Telephone consultation will be provided every other month to supervisors to help institutionalize this case management model. Additionally, supervisors will be provided onsite training by the University of Kansas School of Social Work at a minimum of once a year. We will use a web based recovery markers to measure the outcomes of each person receiving case management services. The recovery markers measured are: living status; employment/education; symptom interference; stages of change for alcohol and drug use; and level of use of alcohol and/or drug use. It is anticipated the mental health centers will be "on line" by the winter of 2007. The Department will develop a core of trainers for strengths based case management. It is anticipated that each SAA will have a minimum of two trainers. The train the trainer will be summer of 2007.

Activities to Reduce Hospitalization

Montana is unique in the access to the state hospital. The hospital is licensed for 189 beds. The Montana State Hospital does not have a "gatekeeper" for admissions to the hospital resulting in lack of control over admissions. The Division contracts with First Health Services to provide two adult care coordinators. The care coordinators work closely with the hospital to ensure more successful community placements. These coordinators are familiar with the community resources available across the state and work cooperatively with community providers to creatively wrap those services around persons discharged from the state hospital to help ensure they are appropriately supported as they transition to community levels of care.

The Department has attempted numerous times to get a preadmission screening bill passed in the state legislature without success. The 2005 Legislative session passed a senate resolution to study the possibility of community crisis plans. The Division is also required to present a plan for crisis services to the Interim Committee and the 2007 Legislative Session. The hospital has three major categories of admissions which are 1) forensics which tends to have long lengths of stay; 2) emergency detentions which average two to five days; and 3) civil involuntaries which average 50-60 days.

Homelessness

The mission of the Governor's Council on Homelessness is: "To *develop and implement strategies to prevent and reduce homelessness in Montana overall and to end chronic homelessness by 2014."* The Council has been in existence since June 2004. Most recently, the Council has begun looking at strategies designed to impact this complex issue as a whole. These strategies include creating a single definition of homelessness in Montana as well as creating common standards for meeting the needs of the homeless persons, including prioritizing them and agreeing not to release anyone into homelessness.

Montana was selected through the Council on Homelessness to be one of the fourteen states and/or cities for the SSI/SSDI Outreach, Access and Recovery (SOAR) project. This has proven to be a highly effective training for case managers who are working with persons who are homeless and have a mental illness. Yvonne Perrette, a nationally recognized expert, piloted this project in Baltimore. The trainers for Montana are Michelle Thibodeau, Disability Determination Services; Sherrie Downing, Governor's Council on Homelessness; and Marcia Armstrong, Addictive and Mental Disorders Division.

This training has been offered to all case managers and supervisors in mental health and substance abuse agencies and Health Care for the Homeless staff. A total of five trainings have been offered in Great Falls, Billings, Helena and Butte for over a hundred thirty persons trained. The Helena training was offered at the Law Enforcement academy for discharge planners from Yellowstone (Billings) county jail, Women's Prison and pre-release case managers. Training is scheduled in September 2006 for case managers at the mental health centers, shelters, and Health Care for the Homeless. Training is scheduled in October 2006 targeted to the Montana State Prison discharge planners.

Waivers

The 2005 Legislative session authorized the Department to apply for the Medicaid Health Insurance Flexibility and Accountability (HIFA) waiver. The proposal was submitted to CMS in June. If approved, the Department can implement the waiver in FY 2007. The proposal would secure Medicaid financing for a portion of the state-funded Mental Health Services Plan (MHSP) that currently provides mental health services and pharmacy benefits to approximately 2,200 people per month who have a severe disabling mental illness but are not eligible for Medicaid. The waiver would enhance the quantity, quality and range of services available to the persons with severe disabling mental illness. The service improvements would include: $1.3 million per year in additional funding for the existing Mental Health Services Plan; a physical healthcare benefit for approximately 1500 MHSP recipients a month, who currently do not have health care coverage; $200,000 per year in Medicaid funding for short term in-patient acute psychiatric benefit; and $240,000 of community block grant to address other system of care issues. Under the waiver, the beneficiaries will have the ability to choose the physical health care benefit that best meets their needs.

Finally, the Department has been authorized to develop a Home and Community Based (HCB) Waiver. The waiver will provide community services to those persons with severe mental illness and other disabling conditions who other wise are in a nursing home. If approved, the waiver would start October 2006 in Billings, Butte in January 2007 and Great Falls in April 2007 for a total of 120 slots. The team would consist of a nurse from the senior and long term care waiver program and a case manager from the mental health center. The waiver was submitted in July 2006.

Medical and Dental

Each community mental health provider is responsible for assessing the medical and dental needs of each client. Those persons with Medicaid are easily served for their medical needs. However, dental care continues to be an ongoing problem for all persons with Medicaid. Persons with MHSP are served through public health clinics and federally qualified clinics that provide medically necessary services for physical and dental health. Medications have been accessed through the federally qualified clinics and Health Care for the Homeless clinics.

Housing Services

The Western Montana Mental Health Center has a full time housing developer. This person has been on staff since the early 1990s. The center has numerous housing options available in the Missoula area. They include: Single Room Occupancy (SRO) apartments, apartments, group homes, detoxification unit, half way house for co-occurring, housing units for women and children, and condominiums available for home ownership. The housing specialist has assisted other communities such as Butte, Hamilton, and Kalispell in obtaining housing options.

The South Central Mental Health Center in Billings has group homes with onsite supervision and one cooperative housing which do not include onsite supervisor rather case managers checking on clients. The Center has good relationships with the Housing Authority and landlords. The

Mental Health Center has received PATH technical assistance in developing a housing project. The center is developing a proposal for a Safe Haven for the 2007 Continuum of Care application. A Billings Council, appointed by the local mayor, is a pilot project under the Council on Homelessness to develop a housing plan for the community.

A.W.A.R.E., Inc. has a fulltime housing developer. They have group homes available in Butte, Glendive and Great Falls. The group home housing has followed the universal design and appears as a duplex with common community areas. They have a capacity of eight persons for each home.

Community mental health centers utilize shelter plus care vouchers which allow persons with mental illness to access housing as well as services to stabilize in the community. The communities of Billings, Missoula, Helena, and Butte have access to these vouchers through the public housing authorities. In addition, Missoula and Helena mental health centers have their own shelter plus care vouchers. A total of 170 shelter plus care vouchers are available with an additional 136 vouchers being requested in 2006.

The Department of Commerce, Housing Division has received twelve shelter plus care vouchers. These vouchers will be available directly to PATH programs in Kalispell, Great Falls and Billings to manage. Kalispell and Great Falls have never had access to shelter plus care vouchers. This is the first time that the Department of Commerce is actually managing shelter plus care vouchers. MHSB and the Housing Division will develop the program prior to implementation. This is a pilot project to develop a collaborative relationship between the Department and the Department of Commerce.

The PATH program applied for technical assistance from the federal agency to develop housing plans for the major communities in Montana. The communities receiving technical assistance are Great Falls, Billings, and Helena. Each of these communities is in different stages of organization and planning. Billings will be developing a Safe Haven project for the next Continuum of Care submission to HUD. The Great Falls mental health center is looking at developing Single Room Occupancies (SRO), they have an opportunity to purchase apartments downtown. The Great Falls Housing Authority is looking at developing two duplexes for the mental health center and possibly have the mental health center use some of Great Falls Housing Authority SROs. Helena is looking at developing a Safe Haven for the 2008 Continuum of Care application submission. Ann Denton and Margaret Lassiter have provided ongoing consultation with each community.

The MHSB is an active member of the Governor's Council on Homelessness. In addition, Division staff members are serving on workgroups addressing housing, special needs population, and access to and delivery of mainstream services.

Corrections and Mental Health

Montana is leading the nation in addressing the needs of this population. The Departments of Corrections and Public Health and Human Services have a signed Memorandum of Understanding to improve access to federal benefits for those with serious mental illnesses

leaving the prison. The MOU resulted from several meetings of staff from both agencies who identified some of the problems faced by mentally ill prisoners re-entering the community. One outcome of these discussions is that individuals in pre-release programs are now eligible for Medicaid or MHSP and have coverage for medication and other mental health services. In addition, the Department of Corrections created several "special needs" slots in pre-release programs for disabled individuals who cannot meet the usual work expectations.

Recently, the Department of Corrections and the Department of Public Health and Human Services have hired a Behavioral Health Program Facilitator who is co-located in the Department of Corrections and the Department of Public Health and Human Services. The position will be dedicated to improving communication, cooperation, and collaboration between the two departments as they rise to the challenge of serving seriously mentally ill people involved in the criminal justice system. The facilitator will focus on improving transitions and placements as offenders leave correctional institutions. The facilitator will support diversion programs designed to appropriately manage and place seriously mentally ill individuals outside of the correctional institutions when possible.

The Mental Health Oversight Advisory Council identified "improved access to mental health treatment for mentally ill prisoners" as one of its top three priorities. This area was identified in part due to the fact the forensic population is the fastest growing population at the state hospital. The Council will focus primarily on those returning to communities in need of mental health treatment, although there is interest in diversion activities and mental health courts.

Goal One: To significantly increase consumer participation and satisfaction in community mental health services.

Indicator One:	Increase the percentage by 4% each year of those adults with SDMI that report involvement in their treatment planning.
Measure:	Numerator: The number of respondents who answered "Agree" or "Strongly Agree" to three survey questions that relate to involvement of the respondent in treatment planning. Denominator: The total number of adult respondents to the Consumer Satisfaction Survey.
Source of Information:	Statewide aggregate data from the Consumer Satisfaction Survey.
Significance:	Taking on that responsibility increases feelings of self-esteem, self worth, dignity and self-respect and increases sense of responsibility for self care.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Performance Indicator	65%	70%	74%	78%
Numerator	262	512		
Denominator	406	702		

Indicator Two: Increase the percentage of those adults with severe mental illness that report positively about their outcomes with mental health services.

Measure: Numerator: The number of respondents who answered "Agree" or "Strongly Agree" to three survey questions relating to access.
Denominator: The number of respondents to the survey.

Source of Information: Statewide aggregate data from the Consumer Satisfaction Survey.

Significance: Consumer choices and responsibility for self care moves the process to recovery and positive outcomes.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Performance Indicator	61%	63%	64%	68%
Numerator	249	446		
Denominator	407	708		

Indicator Three: Increase the percentage each year of adults with serious disabling mental illness that rate the access to services positively.

Measure: Numerator: The number of respondents who answered "Agree" or "Strongly Agree", to three survey questions relating to access, on a five point response.
Denominator: The total number of adult respondents to the Consumer Satisfaction Survey.

Source of Information: Statewide aggregate data from the Consumer Satisfaction Survey.

Significance: Successful access creates a greater potential for positive outcomes.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004	FY 2005	FY 2006	FY

	Actual	Actual	Target	2007 Target
Performance Indicator	81%	80%	81%	82%
Numerator	330	566		
Denominator	408	708		

Indicator Four: Develop at least one peer service for FY 2007.

Measure: The number of programs providing or operating peer support services.

Source of Information: The number of services provided.

Significance: The community mental health providers have not used peer support services in any organized fashion. Montana needs to develop definitions and policies of the use of peer services. This would provide additional capacity for community services.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Target
Performance Indicator	0	0	0	1

Goal Two: **To provide quality community mental health services.**

Indicator One: Increase the number of evidence based practices (EBPs) available for persons served in adult mental health system..

Measure: The number of evidence-based practices provided by the state which adheres to SAMHSA identified fidelity scales for each EBP.

Source of Information: Annual review of service arrays and applicable Fidelity Scales.

Significance: EBPs greatly enhances positive outcomes for persons with SDMI served.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Performance Indicator	2	2	2	>2

Indicator Two: Increase the number of persons receiving Evidence Based Practice services.

Measure: Number of persons receiving EBPs in full accordance with SAMHSA adopted fidelity scales.

Source of Information: Use of reimbursement data base from MMIS.

Significance: The use of Evidence Based Practices enhances positive outcomes for consumers served.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Performance Indicator	152	312	400	500

Indicator Three: Increase the average number of persons served through Assertive Community Treatment (ACT) programs.

Measure: The average number of persons served.

Source of Information: Reports from ACT programs.

Significance: The ACT program has proven to be effective in keeping persons with chronic mental illness in the community with fewer hospitalizations.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Performance Indicator	168	170	293	300

Indicator Four: Develop signed work/employment service agreements between MVR local authority and the local community mental health providers.

Measure: The number of signed service agreements.

Source of Information: Copies of the signed service agreements on file at MHSB.

Significance: Employment is essential to recovery and person centered treatment.

(1)	(2)	(3)	(4)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Target
Performance Indicator	0	2	3

Goal Three: **To support recovery and community integration.**

Indicator One: Continue developing integrated co-occurring services.

Measure: Numerator: The number of providers using Zialogic Tools for assessment of co-occurring capable (COMPASS).
Denominator: Total number of providers to whom the tools were made available.

Source of Information: Report from the Division.

Significance: Addressing these issues in an integrated manner provides more effective treatment.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Numerator	0	12	19	21
Denominator	28	28	28	28

Indicator Two: Collect outcome measures for Assertive Community Treatment (ACT).

Measure: Increase the average hours for education and employment outcomes by 50% in FY 2007.

Significance: The outcomes tracked will continue to provide evidence of the successfulness of the program and benefiting those persons with ACT.

(1)	(2)	(3)	(4)
Fiscal Year	FY 2005 Average	FY 2006 Average	FY 2007 Target
Competitive Work Hours	14	2123	2123+
Non-Competitive Work Hours	>12	405	405+
Volunteer Work Hours	>8	326	326+

Education & Training Hours	>5	202	202+

Indicator Three: Increase the average number of ACT clients work or attend education.

Measure: Average number of ACT clients working or attending education per month.

Significance: Working or attending education programs is crucial in recovery.

(1)	(2)	(3)	(4)
Fiscal Year	FY 2005 Average	FY 2006 Average	FY 2007 Target
Performance Indicator	29	67	67+

Indicator Four: Continue Dialectic Behavioral Therapy (DBT) programs in community, Montana Chemical Dependency Center (MCDC) and MSH.

Measures: a) The number of programs providing DBT.
b) The number of beneficiaries participating in DBT.

Source of Information: Authorizations and paid claims data.

Significance: Access to DBT provides consumer choice and promising practice for those persons with an Axis II diagnosis.

a)	(1)	(2)	(3)	(4)	(5)
	Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Target
	Number of programs	19	22	22	22
b)	Number of clients	35	140	140	

Goal Four: Improve the continuity of care and community reintegration.

Indicator One: Decrease the percentage of persons discharged from the Montana State Hospital who are readmitted within 30 days of discharge each year.

Measure: Numerator: Number of adults readmitted to the MSH within 30 days.
Denominator: Total number of MSH discharges.

Source of Information: Admission/discharge data from MSH.

Significance: Rapid recidivism may reflect ineffective community programs, very serious illness, premature discharge, or noncompliance.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Performance Indicator	6.76%	7%	7%	6%
Numerator	24	45		
Denominator	355	622		

Indicator Two: Decrease the length of stay at the MSH.

Measure: Calculation of the median and mean length of stay for MSH.

Source of Information: MSH admission and discharge data.

Significance: Shorter lengths are imperative to keep people integrated in the community..

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Performance Indicator **Median**	52	48	<48	<48
Performance Indicator **Mean**	94	100	<100	<100

Indicator Three: Decrease the percentage of persons discharged from the Montana State Hospital who are readmitted within 180 days of discharge each year.

Measure: Numerator: Number of adults readmitted to the MSH within 180 days.
Denominator: Total number of MSH discharges.

Source of Information: Admission/discharge data from MSH.

Significance: Rapid recidivism may reflect ineffective or inadequate community programs, very serious mental illness, premature discharge, or noncompliance.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Performance Indicator	12.96%	8.5%	8%	7.5%
Numerator	46	53		
Denominator	355	622		

Goal Five: **To provide case management services to those persons with serious and disabling mental illness.**

Indicator One: Continue the availability of case management services for those who qualify.

Measure: The number of persons receiving case management.

Source of Information: The reimbursement data from MMIS

Significance: Case management is a critical community service that provides necessary support.

Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
# Persons receiving case management	6178	5646	5900	6200

Indicator Two: Develop plan for implementation of strengths based case management in Montana.

Measure: Number of trainings offered to case managers and supervisors.

Source of Information: Attendance sheets from trainings.

Significance: A trained workforce will further person centered planning which respects consumer rights and wishes.

Goal Six: Establish standardized process for transitioning youth with serious emotional disturbance (SED) to adulthood.

Indicator One: Develop transition work group to develop referral process.

Measure: Process established.

Significance: The current system does not provide a positive transition out of the children's mental health system.

CRITERION 2: Mental Health System Data Epidemiology

Freedom Commission:

Goal 3: Consumer/Family Centered Care: *Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.*

Transformation Activities: assuring individualized plans of care for all consumers
removing disparities in access to and quality of care

Incidence and prevalence

The number of adults with serious mental illness in Montana is estimated to be 13,379 at 150% of federal poverty level and 18,820 at the 200% of FPL. This number is based on the number of adults in 2000 census data and application of a methodology developed by WICHE. According to the FY 2006 data a total of 14,404 served. This translates to a 100% penetration rate.

Population Group	Cases	# Served	Penetration Rate	Unmet Need
Total Population	43,327	14,404	33%	67%
<200% FPL	18,8201	14,404	77%	23%
<150% FPL	13,979	14,404	103%	0%

Definition of Severe Disabling Mental Illness (SDMI)

This definition of severe disabling mental illness is based on diagnosis, duration of illness, and level of functioning. The criteria used by Montana are as follows:

"Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the requirements of (a) or (b) or (c). The person must also meet the requirements of (d):

(a) has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital at least once; or

(b) has a DSM-IV diagnosis of
(i) schizophrenic disorder (295);
(ii) other psychotic disorder (295.40, 295.70, 297.1, 297.3, 298.9, 293.81, 293.82);
(iii) mood disorder (296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, , 293.83);
(iv) amnestic disorder (294.0, 294.8);
(v) disorder due to a general medical condition (310.1); or
(vi) pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation;
(vii) anxiety disorder (300.01, 300.21, 300.22, 300.3) or

(c) has a DSM-IV diagnosis of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least 6 months (or for an obviously predictable period over 6 months); and

(d) has ongoing functioning difficulties because of the mental illness for a period of at least 6 months (or for an obviously predictable period over 6 months), as indicated by at least two of the following:
(i) medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;
(ii) the person is unable to work in a full-time competitive situation because of mental illness;
(iii) the person has been determined to be disabled due to mental illness by the Social Security Administration;
(iv) the person maintains a living arrangement only with the ongoing supervision, is homeless, or is at risk of homelessness due to mental illness; or
(v) the person has had or will predictably have repeated episodes of decompensation. An episode of decompensation includes:
- increased symptoms of psychosis
- self-injury
- suicidal or homicidal intent, or
- psychiatric hospitalization.

Mental Health Services Plan Recipients by Service

Services	***FY 05 Individuals***	***FY 06 Individuals****	***FY 05 Net Payments***	***FY 06 Net Payments****
Community Mental Health	*728*	*789*	*$2,122,517*	*$2,227,397*
Licensed Professional Counselor	*2297*	*2523*	*$ 539,590*	*$ 600,658*
Mid-Level Practitioners	*261*	*278*	*$ 53,830*	*$ 44,186*
Psychiatrists	*1655*	*1914*	*$ 562,701*	*$ 773,437*

Psychologists	*163*	*178*	*$ 45,157*	*$ 42,395*
Social Workers	*1574*	*1765*	*$ 390,723*	*$ 626,591*
Targeted Case Management	*2485*	*2640*	*$2,911,326*	*$3,329,404*
Pharmacy Program	*3104*	*3383*	*$2,943,166*	*$3,060,161*
Total	*4933*	*5329*	*$9,569,010*	*$10,704,229*

Pharmacy program recipient and costs are based on actual paid claims.
Other service cost and recipient counts are based on encounter data.

Medicaid Mental Health Services by Services and Paid Claims

Services	***FY 05 Individuals***	***FY 06 Individuals****	***FY 05 Net Payments***	***FY 06 Net Payments****
Community Mental Centers	*1854*	*1936*	*$13,573,740*	*$14,253,183*
Inpatient Hospital	*665*	*598*	*$ 1,829,413*	*$ 1,520,521*
Licensed Professional Counselors	*3556*	*3358*	*$ 1,245,515*	*$ 1,181,733*
Physicians	*5700*	*5581*	*$ 446,111*	*$ 475,630*
Psychiatrists	*3938*	*3942*	*$ 1,257,609*	*$ 1,432,465*
Psychologists	*1001*	*885*	*$ 243,363*	*$ 234,348*
Social Workers	*2057*	*2023*	*$ 551,891*	*$ 576,900*
Lab and x-ray	*404*	*419*	*$ 26,683*	*$ 29,244*
Personal Care	*243*	*245*	*$ 1,080,025*	*$ 1,287,898*
Federally Qualified Health Centers	*1298*	*1186*	*$ 266,543*	*$ 234,083*
Rural Health Clinics	*764*	*693*	*$ 152,448*	*$ 137,426*
Mid-Level Practitioners	*2454*	*2392*	*$ 298,429*	*$ 300,290*
Targeted Case Management	*3624*	*3607*	*$ 9,471,965*	*$ 9,244,788*
Outpatient Hospital	*2497*	*2499*	*$ 391,745*	*$ 367,327*
TOTAL	*13,554*	*13,150*	*$30,835,480*	*$31,275,836*

Source: ACS 701Reports and ACS Query Path Decision Support Software

** Information is not complete. Information is through August 25, 2006. Providers have 365 days to file a claim.*

The MHSP is administered through contracts with four Community Mental Health Centers for a fixed contract amount. In FY 2006, the contract total was $4,468,814.

All services are provided through a Community Mental Health Center with the exception of pharmacy services. Practitioners identified above provide services through the Community Mental Health Center.

The actual number of persons served by age and ethnicity for FY 2005 is as follows:

Age	Female	Male	Total
18-20 year	811	540	1351
21-64 year	9459	5199	14,658
65-74 year	548	259	807
75+ year	1012	329	1341
Total	11,830	6327	18157

	American Indian or Alaska Native		Asian or Pacific Islander		Black or African American		White		Hispanic	
Age	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*
18-20 years	134	67	4	2	9	1	626	437	25	12
21-64 years	1121	413	27	8	57	35	7754	4296	208	77
65-74 years	43	17	2	0	2	2	492	229	3	2
75+ years	37	13	3	0	1	3	958	304	11	2
Total	1335	510	36	10	69	41	9830	5266	247	93

Goal One: A comprehensive, accessible, community-based mental health system will be available for those qualified persons with SDMI.

Indicator One: Provide ACT for those persons that meet criteria.

Measures: Number of persons served.
Number of providers trained in providing ACT

Significance: A vital service for those persons that otherwise may be at the

Fiscal Year	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Number Served	168	170	276	325
Number Providers	2	5	5	5

Indicator Two: Provide DBT for those persons that meet criteria**.**

Measure: Number of persons served.
Number of programs trained in DBT.

Fiscal Year	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Number Served	29	55	140	140+
Number Providers	16	22	22	22

Goal Two:	**Utilize the results of the WICHE study to plan for the mental health system.**
Indicator One:	Develop a task force to review the results of the study.
Measure:	Task force established with meetings scheduled.
Source of Information:	Attendance and reports.
Significance:	The study from WICHE has many implications in the provision of mental health services. Need to understand those implications and develop a plan in appropriate provision of services to the sub populations of Montana.

CRITERION 3: CHILDREN'S SERVICES
Not applicable

CRITERION 4: Targeted Services to Rural and Homeless Populations

Freedom Commission:

***Goal 1: Mental Health is Essential to Health**: Every individual, family and community will understand that mental health is an essential part of overall health.*

***Goal 3: Consumer/Family Centered Care:** Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.*

Transformation activities:
reduction of the stigma associated with mental illness
linking mental health care with primary care
facilitating access to and quality of care
improving coordination of care among multiple systems
development of culturally competent services

For planning mental health services, Montana is an entirely rural state and its mental health system is a rural mental health system. The extent to which this mental health system serves Montana's huge geographic area is impressive. The public mental health system provides professional mental health services in counties with as few as 1.66 people per square mile (Beaverhead County), and part-time professional mental health services in 26 counties with as few as 0.27 people per square mile (Garfield County).

The Eastern Montana Telemedicine Network has been operational since September 1993 and presently has nineteen partner sites in Montana and 2 sites in Wyoming. Telemedicine ensures a continuum of mental health care throughout Eastern and Central Montana. Ninety-four percent of the patients seen over telemedicine were retained in their local community. 96% of the

providers identified that consumers seen over telemedicine would have been referred out of the community if the technology had not been available. Mental health services provided include: medication review; follow up visits to monitor progress; discharge planning; individual and family therapy; emergency consultation; and employee assistance.

SOAR

Montana was selected to be one of the fourteen states and/or cities for the SOAR project. SOAR is the acronym for SSI/SSDI Outreach, Access and Recovery. This has proven to be a highly effective training for case managers who are working with persons who are homeless and have a mental illness. Yvonne Perrette, a nationally recognized expert, piloted this project in Baltimore. The trainers for Montana are Michelle Thibodeau, Disability Determination Services; Sherrie Downing, Governor's Council on Homelessness; and Marcia Armstrong, Addictive and Mental Disorders Division.

This training has been offered to all case managers and supervisors in mental health and substance abuse agencies and Health Care for the Homeless staff. A total of five trainings have been offered in Great Falls, Billings, Helena and Butte for over a hundred thirty persons trained. The Helena training was offered at the Law Enforcement academy for discharge planners from Yellowstone (Billings) county detention center, Women's Prison and pre-release case managers from Butte. Training is scheduled in September for case managers at the Helena mental health center, shelters, and Health Care for the Homeless. Training is scheduled in October targeted to the Montana State Prison discharge planners.

The project will be collecting and reporting on outcome data which will assess the effectiveness of Montana's plan to increase access to disability benefits. Through the SOAR project one person who was homeless qualified for SSI in spring 2006. It is estimated approximately 50 SOAR applications will be submitted for disability determination this year.

PATH

Three community mental health centers receive funding for PATH programs. They are:

1. South Central Mental Health Center receives a total of $113,566 of which $85,174.50 is federal funds and $28,391.50 is general funds. Billings' community has three full time PATH workers with one being the supervisor.
2. Golden Triangle receives a total of $106,105 of which $79,278.75 is federal funds and $26,526.25 is general funds. Funds are provided to Great Falls and Helena communities for full time PATH case managers.
3. Western Montana Mental Health Center receives a total of $158,329 of which $118,746.75 is federal funds and $39,582.25 is general funds. The communities of Kalispell, Missoula and Butte have full time Path case managers.
4. Additional funds are withheld for training purposes which include:
    - Attendance at annual Mental Illness Conference
    - Quarterly PATH meetings

The total number of persons served for FY 2005 was 1713. Of this number 738 were enrolled PATH clients. These are not enrolled mental health center clients.

Demographics of the enrolled PATH clients:

- Age – 41% are between 35-49 and 42% are between 18-34
- Gender – 65% are male and 35% female
- Race – 82% are Caucasians and 7% are American Indian
- Principal Diagnosis – 37% have a diagnosis of affective disorders and 26% had other serious mental illness (other than schizophrenia, personality disorders or other psychotic disorders)
- Co-Occurring Substance Abuse Disorders – 58% have a co-occurring substance abuse disorder
- Veteran Status – 67% are non-Veterans
- Housing Status – 38% are living in short term shelter, 20% are living in own or others dwelling and 12% are living outdoors
- Length of Time Outdoors/short term shelter – 43% for two to 30 days, 28% are at 31 to 90 days, 10% are 91 days to 1 year and 9% are over 1 year

All enrolled PATH clients received outreach and case management services. 81% of the enrolled PATH clients received assistance in applying for housing; 45% received financial assistance in seeking housing, 36% received screening and diagnostic services, and 85% received referral to primary health services.

The PATH case managers will be using the Recovery Markers web based measures. It is hoped that we will be able to better track the results of case management for the homeless population as they use PATH case management services and then the mainstream mental health services. The measures that will be tracked quarterly are: living status; employment/education; symptom interference; stages of change for alcohol and drug use; and level of use of alcohol and/or drug use.

Other Homelessness Activities

Continuum of Care Point-in-Time Homeless Population and Subpopulations Chart

Indicate date of last point-in-time count:___ 1/31/06 _____

Part 1: Homeless Population	**Sheltered**		**Unsheltered**	**Total**
	Emergency	**Transitional**		
Number of Families with Children (Family Households):	64	66	15	145
1. Number of Persons in Families with Children:	221	196	42	459
2. Number of Single Individuals and Persons in Households without Children:	283	179	410	872
(Add Lines Numbered 1 & 2) Total Persons:	504	375	452	1331

Part 2: Homeless Subpopulations	**Sheltered**	**Unsheltered**	**Total**
a. Chronically Homeless (For sheltered, list persons in emergency shelter *only*)	37	111	148
b. Severely Mentally Ill	108	* 59	167
c. Chronic Substance Abuse	83	* 73	156
d. Veterans	88	* 94	182
e. Persons with HIV/AIDS	5	* 3	8
f. Victims of Domestic Violence	104	* 29	133
g. Unaccompanied Youth (Under 18)	26	* 3	39

The mission of the Governor's Council on Homelessness is: "To *develop and implement strategies to prevent and reduce homelessness in Montana overall and to end chronic homelessness by 2014."* The Council has been in existence since June 2004. Most recently, the Council has begun looking at strategies designed to impact this complex issue as a whole. These strategies include creating a single definition of homelessness in Montana as well as creating common standards for meeting the needs of the homeless persons, including prioritizing them and agreeing not to release anyone into homelessness. As Montana's planning body for formulating and affecting change in the policies and practices that play a role in homelessness, the MHSB and PATH program are actively involved in the Council and workgroup activities.

Goal 1: **Individuals who are homeless and have SDMI will have access to mental health services.**

Indicator One: **Persons with serious mental illness outreached will be PATH enrolled.**

Measure: Numerator: The number of persons enrolled in PATH services. Denominator: The total number of persons who are contacted by PATH case managers and have a serious mental illness.

Source of Information: PATH annual report.

Significance: PATH services increase a person's ability to move towards recovery.

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Performance Indicator	45%	41%	45%	50%
Numerator	987	738		

Denominator	2220	1816

Indicator Two**:** Develop recovery markers to determine outcome measures for persons receiving case management.

Measure: The number of programs using the recovery markers in their case management services.

Source of Information: Strengths Based Recovery Markers

Significance: The Recovery Markers measure the outcomes necessary for persons in recovery.

Goal 2: **Mental Health Services Bureau will participate in the SOAR project.**

Indicator One: Train case managers and supervisors on SOAR**.**

Measure: The number of persons receiving training.

Source of Information: Attendance sheets from training sessions.

Significance: SOAR provides another avenue to access appropriate services.

(1)	(2)	(3)
Fiscal Year	FY 2006 Actual	FY 2007 Target
Performance Indicator	130	90

Goal Three: **Ensure housing is available to persons with serious disabling mental illness.**

Indicator One: Participate in the Governor's Council on Homelessness.

Measure: Attendance in meetings and activities.

Significance: Participation will ensure persons who are homeless and have a mental illness are included as a target population.

(1)	(2)	(3)
Fiscal Year	FY 2006 Actual	FY 2007 Target
Performance Indicator	5	5

Indicator Two: Plans for housing development submitted to funding agencies.

Measure: Number of plans.
Significance: Housing is crucial for persons who are homeless.

Goal Four: Ensure training is made available to programs serving frontier counties.

Indicator One: Frontier programs participate in the training for DBT.

Measure: Attendance sheets from trainings sessions

Significance: Consumer access to quality community services.

Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
# Programs trained in DBT	0	2	4	

Indicator Two: Frontier programs participate in the training for Co-occurring.

Measure: Attendance sheets from trainings sessions

Significance: Consumer access to quality community services.

Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
# Programs trained in Co-Occurring	4	6	>6	>6

Indicator Three: Frontier programs participate in the training for Strengths Base Case Management.

Measure: Attendance sheets from trainings sessions

Significance: Consumer access to quality community services.

Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
# Programs trained in Case Management	n/a	4	>6	>6

Goal Five:	**Ensure respectful and culturally competent services within the mental health system.**
Indicator One:	Provide cultural competency training to providers and other stakeholders**.**
Measure:	Definition of cultural competence using established models from other similar regions.
Indicator Two:	Provide cultural competence training
Measure:	Attendance sheets from training sessions.
.	
Indicator Three:	Develop a resource library.
Measure:	Resource list available on the state's website.
Significance:	It is essential providers are culturally competent.

CRITERION 5: Management Systems

Staffing

The Mental Health Services Bureau has a bureau chief, quality assurance manager, program manager, regional planner, and two human services position. In addition, the bureau receives support from the administrator's office. Six full time staff have managed community mental health services. The bureau received five community program officers, three in FY 2006 and two in FY 2007. Five licensed mental health centers in conjunction with private providers provide the services for those persons with severe and disabling mental illness. The Medicaid providers are enrolled and have billed in the last year. This network includes 146 psychologists, 209 social workers, 453 licensed professional counselors, and 65 psychiatrists.

First Health provides two contracted adult coordinators. These coordinators work closely with the state hospital and providers to ensure appropriate community placement.

DPHHS has entered into an agreement with Comprehensive Neuroscience (CNS) to improve prescribing practices for mental health prescription drugs. CNS, in cooperation with the drug utilization review board provides education on best practices for prescribing. This has proven to save thousands of dollars in prescribing practices in other states.

Efforts to recruit and retain qualified professionals to work in Montana's public mental health system continue. A practicum is available for nursing students at Montana State Hospital as well as internships and field placements for students in psychology, counseling, and recreation therapy. Additionally, licensed mental health centers provide the opportunity for students who have completed the academic requirements for licensure to work under supervision for the

required period of time before becoming eligible for the licensing examination. Taking advantage of loan forgiveness incentives associated with working in Health Professional Shortage Areas also assists with recruitment. The results of the loan forgiveness for psychiatrists have been poor. The Division increased the reimbursement rate for the psychiatrists.

The Mental Health Services Bureau has five persons in the central office that oversee community mental health for the state of Montana. In addition, the bureau has five community program officers. The field staff will help further the Service Area Authority efforts, work to develop needed community crisis services, and provide a direct contact for community persons.

The Department has proposed a workforce development project in partnership with WICHE to be funded during the 2007 Legislative session. There is also an ongoing issue of ensuring that training programs are preparing students to effectively work in the 21st century public behavioral health treatment setting that include a co-occurring (mental illness and chemically or alcohol dependent) treatment philosophy and evidence based treatment practices.

Training of Consumers and Family members

Montana invests some resources to support the training opportunities for consumers, family members, providers, and other stakeholders. The Department will continue it's funding for education programs provided by NAMI for consumers, family members, and providers. The Bureau will partner with the Montana Mental Health Association in FY 2007 to train facilitators for Wellness Recovery Action Plans (WRAP). Each SAA will have a minimum of two trainers. We plan a total of ten WRAP trainings for FY 2007. MHSB provides additional funds for the annual Mental Illness conference. Over 150 consumers attend the Mental Illness Conference annually.

For FY 2006 NAMI-MT has provided four Peer-to-Peer sessions with 34 participants. One "Support Group Facilitator Training" was conducted with twenty-one persons being trained as facilitators. The Support Group Facilitators are in 10 communities, some held monthly and some every two weeks groups. Average attendance in groups was seven to fifteen.

Five Family to Family sessions were held with 77 participants. Seven new " Family to Family" teachers were trained.

The NAMI "In Our Own Voice" has made twenty-one presentations and reached 286 persons. One training for presenters of "In Our Own Voice" trained sixteen new presenters.

Training of Providers

MHSB contracts with Ziologic to provide ongoing consultation on the implementation of Co-Occurring Disorders in Montana. Clinical training activities have included motivational interviewing, stages of change, and integrated treatment planning.

The MHSB will be providing an advanced training in Dialectical Behavior Therapy (DBT) in October. The focus for the next year will be to provide ongoing support to the existing teams.

Training on Employment and the Strength's Based Assessment will be provided in August 2006. This will be a combination of vocational rehabilitation counselors and mental health supportive employment specialists. The outcome of the training expected to be a better working relationship between the two agencies and better outcomes for the consumers.

A Trainer of Trainers for strength based case management will be provided in 2007. It is important that Montana build the capacity to provide ongoing training to case managers, rather than rely on out of state consultants. In addition, we will be purchasing video materials to be available to all programs for ongoing education of the case managers.

Crisis Services and Training

Helena sent at team to Memphis for the 40-hour Community Intervention Team (CIT) training. This team has provided training to law enforcement officers in Montana. The law enforcement agencies in Helena have provided a great deal of support for implementation of CIT in the community. The biggest obstacle for full implementation has been the lack of crisis services beyond the emergency room of the community hospital. Through a community collaborative effort the Center for Mental Health in Helena opened a crisis stabilization center in June 2006.

The Billings community identified crisis services for persons with co-occurring disorders as a priority. The Deaconess Hospital, Deering Clinic, St. Vincent Hospital and South Central Mental Health Center have created a separate a separate corporation to address this issue. The crisis center opened spring 2006. The facility has access to psychiatrists, physicians, nurses, therapists and case managers. Each agency provides staff for the facility.

In addition, Billings Clinic Behavioral Health (consisting of 9 full-time psychiatrists) partners with the South Central Montana Regional Mental Health Center and two private practice psychiatrists to provide on-call and psychiatric services to Billings and the Eastern region.

The grants awarded to the communities of Butte, Helena, Great Falls, Hamilton, Billings and Eastern Montana in July 2006 will move communities to more developed crisis services. These services will include WRAP training, CIT training and collaboration between agencies.

The Mental Health Services Bureau community program officers will be working with local communities to plan for and implement crisis services. The MHSB will be working closely with the SAAs, LACs, Council, county and city officials, providers and other stakeholders to develop a plan that can be taken to the 2007 Legislature.

The Children, Families, Health and Human Services Interim Committee have been reviewing community mental health crisis services. This has included: where the responsibility lies or should lie for providing crisis services in the community; planning and development of services; what and how services should be provided at the community level; what populations should be served; how to encourage cooperation between and within communities in the planning, development and provision of services; and the funding and cost consideration of crisis services.

The Committee's study and recommendations will be completed by September 15, 2006 for possible submission to the 60th Legislature.

Consumer and Family Member Participation in Planning and Decision-making

MHSB will continue its long-standing commitment to collaboration with consumers and family members. The Mental Health Oversight Advisory Council, Local Advisory Committees, Service Area Authorities, and ongoing relationship with the Mental Health Ombudsman are examples of this collaboration.

By law SAAs are required to have 51% consumer and family member representation on each board. Consumers and family members are encouraged to participate in decision making at the local level. The LAC each determines the allocation of community mental health resources.

Data Infrastructure Grant

The Data Infrastructure Grant is to develop a data infrastructure in each of the states and territories. The Uniform Reporting System allows for the exchange of state and federal data for planning purposes and demonstration of effectiveness. DPHHS and the Department of Justice have entered into a data sharing agreement. The Department will be receiving arrest records from the Department of Justice.

The MHSB hopes to have a Behavioral Health Analyst position by fall 2006. The analyst position will be reviewing data currently received and developing reports for all key stakeholders for trend analysis and outcome measures.

Use of Block Grant Funds

The CMHS Mental Health Block Grant allocation for Montana is estimated to be $1,236,408. In FY2007 Montana will use all block grant funds for services for adults with severe disabling mental illness. The program activities supported by block grant funds are part of the Mental Health Services Plan and all funds will be used to purchase community-based services.

The funds available for the adult mental health system in FY 2006 are $44,148,481 and $45,266,309 for FY 2007. Mental Health Services include ACT, MHSP, Intensive Community Based Psychiatric Rehabilitation, Intergovernmental transfers, mental health block grant and Medicaid. FY 2007 includes the Home and Community Based Waiver. The Mental Health Administration includes funding for the Helena staff and the new field staff.

Federal block grant and general funds are used to contract with the mental health centers to provide community services to those persons that qualify for MHSP. General funds are used for the pharmacy emergency funds for each community mental health center. The table below is the contracted funds for FY 2006. The FY 2007 funds will be dependent on the HIFA waiver. If the waiver is not successful, the contracts will be the same as FY 2006. If the waiver is successful, $1,008,901 will be included in the contracts for services to adults eligible for the

Mental Health Services Plan. The remaining, $240,000, will be made available to SAAs. Each SAA will develop a proposal for $80,000 to meet identified needs.

Funds (FY 2007)	MHSP	Block Grant	Pharmacy
Eastern Montana MHC	461,544	159,854	6,829
Center for Mental Health MHC	722,876	258,225	16,608
South Central MHC	747,801	269,365	17,543
Western Montana MHC	1,500,925	541,044	34,020
TOTAL	3,433,146	1,228,429	75,000

Goal One: **Increase the number of persons with prescriptive authority in Montana**

Indicator One: Increase the number of prescriptive providers serving the SDMI population.

Measure: Number of prescriptive providers.

Source of Information: The ACS data.

Significance: Increased access provides better psychiatric access for the SDMI population.

Indicator Two: To increase individuals receiving psychiatric services.

Measure: To determine if the increase in psychiatrists will increase access to services.

Source of Information: ACS data system

Significance: Increased provider rate will provide better psychiatric access for the SDMI population.

	(1)	(2)	(3)
Indicator	FY 2005 Projected	FY 2006 Target	FY 2007 Target
Number of Psychiatrists	46	65	65
Number of Individuals	2142	>2142	>2142
Number of Mid Levels	245	245	>245
Number of individuals	n/a	n/a	n/a

Goal Two: **Develop a plan for crisis services**

Indicator One:	MHSB will work closely with the Mental Health Oversight Advisory Council on crisis services.
Measure:	Strategy for crisis services in Montana
Source of Information:	Minutes from Council meetings
Significance:	Crisis services are a priority.
Indicator Two:	Evaluate current crisis services
Measure:	Services available
Source of Information:	AMDD report
Significance:	Creating a baseline will help determine next steps.
Indicator Three:	Plan will be developed to provide training of emergency health providers (first responders).
Measure:	Training provided to emergency health providers.
Source of Information:	Information provided from Community Program Officers, LACs and SAAs.
Significance:	Often the emergency room or law enforcement are the first intervention for persons in psychiatric crisis.
Goal Three:	**Support and enable persons with severe disabling mental illness and family member participation.**
Indicator One:	Maintain a minimum of 51% persons with severe disabling mental illness and family membership on Mental Health Oversight Advisory Council.
Measure:	Numerator: The number of family and consumer members Denominator: The total number of members.
Source of Information:	Advisory Council roster of membership
Significance:	Consumers and family members are critical to the development of mental health services in Montana.

(1)	(2)	(3)	(4)
Fiscal Year	FY 2005 Actual	FY 2006 Target	FY 2007 Target

Performance Indicator	63%	56%	51%
Numerator	19	17	
Denominator	30	29	

Indicator Two: Support the Local Advisory Councils (LAC) across the state.

Measure: Staff support to LAC by community program officers and regional planner.

Source of Information: Summaries of reports from LACs, community program officers and regional planner

Significance: Staff support will assist in local system development.

(1)	(2)	(3)	(4)
Fiscal Year	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Performance Indicator	15	26	>26

Indicator Three: Support Service Area Authorities (SAA) across the state**.**

Measure: Staff support to SAA by community program officers and regional planner.

Source of Information: Summaries of reports from SAA, community program officers and regional planner

Significance: Ensuring the success of the SAAs further the goals of system development.

Goal Four: Support education for persons with severe disabling mental illness, family members, and providers

Indicator One: Contract with NAMI to provide the following training:

a) Family to Family education program offered in a minimum of three communities in Montana
b) Support Group Facilitator training
c) "In Our Own Voice" Living with Mental Illness offered in three communities
d) Provider Education Course offered in two communities
e) Peer to Peer Recovery Course offered in three communities

Measure: a) Number of courses and training provided

Source of Information: Report from NAMI trainers

Significance: Education on severe mental illness supports the recovery process.

(1)	(2)	(3)	(4)
Fiscal year	FY 2005 Actual	FY2006 Target	FY2007 Target
Number of Family to Family	>3	>3	>3
Number of Support Group Facilitator	>1	>1	>1
Number of "In Our Own Voice"	1	1	3
Provider Education	2	2	2
Peer to Peer	3	>3	>3

Goal Five: **Provide training to community mental health providers and state approved alcohol and drug programs.**

Indicator One: Develop a Train the Trainers model for case management**.**

Measure: Persons attending Training of Trainers for case management.

Source of Information: Attendance and letters of invitation

Significance: To build capacity within the state.

Indicator Two: Develop statewide training plan in co-occurring.

Measure: Training plan developed and implemented.

Source of Information: Written plan

Significance: Provide a roadmap for the co-occurring initiative and will allow the state and stakeholders to evaluate the initiative.

Goal Six: **Collect and utilize data from the recovery markers.**

Indicator One: Have programs begin submitting data in winter 2007.

Measure:	Date submitted
Source of information:	The web access program
Significance:	Providers will utilize the outcomes to determine the individual needs of consumers. Supervisors will be better equipped to train case managers.
Indicator Two:	Train supervisors on the usefulness of the recovery marker data.
Measure:	Training held and number attended
Source of Information:	Attendance sheets from training.
Significance:	This moves the mental health system to a recovery based and person centered system.
Indicator Three:	Reports developed for MHSB and the programs.
Measure:	Developed reports
Source of Information:	Reports
Significance:	The reports will help the mental health system keep outcomes in the fore front.
Goal Seven:	**Collect data from the mental health centers for performance measures.**
Indicator One:	75% of data fields completed in performance data submissions by providers.
Measure:	Data fields completed and accurate.
Significance:	With more accurate and complete data we can better measure the effectiveness of the mental health system.
Indicator Two:	Develop benchmarks for improved completion of data fields.
Measure:	Baseline for benchmarks developed.
Significance:	With more accurate and complete data we can better measure the effectiveness of the mental health system.

Goal Eight:	**Allocate Community Mental Health Block Grant for persons with severe disabling mental illness.**
Indicator One:	Block Grant funds of $1,236,408 will be included in the contracts for services to adults eligible for the Mental Health Services Plan in FY 2007, if HIFA waiver is not approved.
Indicator Two:	If waiver approved in FY 2007, $96,408 will be included in the contracts for services to adults eligible for the Mental Health Services Plan. The remaining, $240,000, will be made available to SAAs. Each SAA will develop a proposal for $80,000 to meet identified needs.